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Counseling & peer education

Peter Winch

Health Behavior Change at the Individual, Household and Community Levels 224.689
Today

- Orphans and HIV/AIDS
- Final assignment: Steps toward a behavior change intervention
- Counseling
- Peer education
Orphans and HIV/AIDS
Orphans and HIV/AIDS

- Children are affected in many ways by HIV/AIDS
- While the needs are enormous, there has been a lot of controversy over terminology, search for the right terms
Orphans and HIV/AIDS: Search for the right term

- Definition of NGOs/government may not match local definitions of orphan
- Some current terms:
  - OVC: Orphans and other vulnerable children
  - Children affected by HIV/AIDS
  - Children without parental care (UNICEF)
Question: Definition in Uganda

- How might definition of orphan differ in parts of Uganda where land organized into areas where people are descended from a common male ancestor, and land communally owned by the descent group?
Steps toward a behavior change intervention
Steps toward a behavior change intervention

- The next few slides show steps I want you to go through in your thinking as you work on the final assignment
- I recommend a conservative approach to intervention
  - Proceed systematically
  - Be cognizant of potential for unintended consequences
Steps toward a behavior change intervention

1. Do you understand the epidemiology and ecology of the problem?
2. Do you have good reason to believe a behavior change intervention would be beneficial?
3. What will be the content of your intervention?
Steps toward a behavior change intervention

1. Do you understand the epidemiology and ecology of the problem?
   – Do you yourself understand it?
     • NO ➔ Read up on it
   – Does anyone understand it?
     • NO ➔ Conduct basic research about the problem
Steps toward a behavior change intervention

2. Do you have good reason to conclude that a behavior change intervention would be beneficial? (Question #1, in part)
   - Do you have a recommended behavior, do you know what you want people to do?
   - Is there evidence that practicing the behavior is effective/has an impact?
   - **AFASS**: Is behavior acceptable, feasible, affordable, sustainable and safe?
Steps toward a behavior change intervention

1. Do you understand the epidemiology and ecology of the problem?
2. Do you have good reason to believe a behavior change intervention would be beneficial?
3. What will be the content of your intervention?
Steps toward a behavior change intervention

3. What will be the content of your intervention?
   - Last class: Talked about thinking about intervention content by level
## Multi-level interventions: Adolescent smoking

<table>
<thead>
<tr>
<th>Level</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Increase perceived severity and personal risk of smoking related illness, increase self-efficacy to refuse cigarette offered by peer</td>
</tr>
<tr>
<td>Household</td>
<td>Designate no-smoking areas in home</td>
</tr>
<tr>
<td></td>
<td>Encourage parents to not smoke in front of children and not offer cigarettes to children</td>
</tr>
<tr>
<td>Community or county</td>
<td>No-smoking by-laws for schools and restaurants, community norms re smoking</td>
</tr>
<tr>
<td>State/country</td>
<td>Taxes on cigarettes, laws on sale of cigarettes to minors</td>
</tr>
</tbody>
</table>
# Final assignment matrix for Scenario #2

**Scenario selected**: #2, Micronutrients – refugees

<table>
<thead>
<tr>
<th>Level</th>
<th>Applicable concepts or models</th>
<th>Possible actions/interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugee camp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization (UNHCR, NGOs)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Steps toward a behavior change intervention

3. What will be the content of your intervention?
   – Information and channels of communication
   – Commodities, technologies and channels of distribution/sale
   – Processes, activities
   – People
Information

• Behavioral recommendation: What, when, where
• Steps in doing the behavior
• Advantages to adopting the behavior
  o What disease(s) will be prevented
  o People will be impressed by you

People
Information

People

• Person who will practice the behavior
• Family/household members
• Community leaders, opinion leaders, other influentials
• Health care providers
Information

People
Channels of communication

**Impersonal**
- Newspaper articles
- Posters
- TV/radio serials
- TV/radio spots/ads
- Billboards
- Fliers, pamphlets
- Stickers, buttons
- Hats, shirts

**Interpersonal**
- Counseling
  - Individual
  - Group
- Peer education
- Diffusion through social networks
- Community groups/participatory processes
Channels of communication: Relative strengths

Impersonal

Interpersonal
Channels of communication: Relative strengths

Impersonal
- Easier to scale up
- Can quickly attain high coverage
- Repetition/high frequency is possible
- Low cost per person reached
- Easy to standardize the message

Interpersonal
- May be more convincing
- Better for complex, multi-part messages or transfer of skills
- Can be adapted to individual needs
- Can reach isolated or marginalized populations
Example for Q2 and Q3

  - Section "Theoretical Foundations for Intervention" on pp 424-425 together with Table 1 on p 424 is an example of how you might approach Question 2
  - Section "Project Accept Intervention Components" on pp 425-526 is an example of how you might approach Question 3.
Counseling as a public health intervention
Counseling: Contrasting approaches

- Clinical counseling by highly-trained professionals
- Counseling as a public health intervention
Clinical counseling by highly-trained professionals

- Many types of professionals conduct clinical counseling: social worker, psychologist, nurse, paramedic, physician etc.
- Many years of training required
  - Professional examinations
  - Certification/licensing
Counseling as a public health intervention

- Aims for high coverage
  - Recruit and train counselors with lower level of education
  - Simplified counseling guidelines allow for larger scale training and supervision
- Focus on limited set of behaviors related to program’s objectives
  - Doesn’t try to address all of the client’s problems
## Counseling as a public health intervention

<table>
<thead>
<tr>
<th></th>
<th>Clinical/specialized</th>
<th>Public health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselors</td>
<td>Psychologist, psychiatrist, social worker, nurse, paramedic, physician etc.</td>
<td>CHW, peer educator, health worker in first level facility</td>
</tr>
<tr>
<td>No. of sessions</td>
<td>Multiple, cumulative</td>
<td>One, sometimes two</td>
</tr>
<tr>
<td>Assessment</td>
<td>Detailed, may take one or more entire sessions</td>
<td>Simple, often quick categorization</td>
</tr>
<tr>
<td>Clinical data part of</td>
<td>Often extensive use of clinical and other data</td>
<td>No, or limited to 1-2 tests e.g. HIV test</td>
</tr>
<tr>
<td>assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length</td>
<td>Variable, but sometimes one hour or longer</td>
<td>Usually brief, 5-20 min.</td>
</tr>
<tr>
<td>Cost</td>
<td>Often paid</td>
<td>Often free of cost</td>
</tr>
<tr>
<td>Location</td>
<td>Typically in health facility</td>
<td>Facility, mobile clinic, home, community center</td>
</tr>
</tbody>
</table>
Counseling as a public health intervention

- Client-Centered, but relatively little tailoring to individual needs
- Not psychotherapy
- Informational, non-judgmental
- Often uses an algorithm or flow chart
- May include referral to other care
- Quality assurance is critical ➔ No counseling may be preferable to poor quality counseling
When does counseling make sense as an intervention?

- Behavioral recommendations must be adapted to individual circumstances
  - Individual clinical features
  - Individual risk profile
- Series of decisions to be made, each depends on the previous one
- Behaviors occurring in the private/domestic domain
Examples where counseling plays a central role

- Voluntary counseling and testing for HIV
- Family planning/healthy fertility
- Antenatal care for maternal and newborn care practices
- Domestic violence
- Substance abuse/addiction
- Breastfeeding
- Weaning practices
Voluntary Counseling and Testing for HIV/AIDS
VCT is part of the ‘traditional’ HIV/AIDS prevention triangle

VCT

Condoms

Treatment of STIs

Concerns about evidence base for all three as preventive measures
A replacement triangle?

- Treatment as prevention
- Pre-exposure prophylaxis
- Male circumcision
- + others
Voluntary Counseling and Testing for HIV/AIDS

- VCT services are:
  - Prevention tool
  - Entry point into care, ART, PMTCT
- Raise awareness about HIV in communities
- Reduce stigma and discrimination associated with the infection
Voluntary Counseling and Testing for HIV/AIDS

- Ethical concerns:
  - Violence against those testing without partner permission
  - Violence and stigma against those with positive results
Voluntary Counseling and Testing for HIV/AIDS

Steps people need to take:

- Seek info/visit clinic
- Get tested
- Learn test results
- Disclosure => partner testing, future prevention, living positively, future testing, etc.
HIV testing: Opt-in or opt-out?

- **Opt-in approach**
  - Pre-test counseling: What is an HIV test, what are you agreeing to?
  - Ask person if they want to take the test, they must ‘opt in’ or they aren’t tested
  - Post-test counseling for positives and negatives: Negatives told about prevention, positives told about coping, care and treatment alternatives

- **Opt-out approach**
HIV testing: Opt-in or opt-out?

- **Opt-in approach**
- **Opt-out approach**
  - Minimal pre-test counseling
  - HIV test is a routine test, routine part of care, not something unusual or scary
  - Everyone gets tested unless you specifically state you do not want to be tested
  - Focus is on post-test counseling, and is primarily for people who test positive
  - In contrast to VCT, negatives may be given a pamphlet, or receive no information at all
HIV testing: Opt-in or opt-out?

- Concern that restricting testing to situations where full VCT services are available greatly reduces the number of people tested
- Some are less concerned about possibility of testing without counseling due to wider availability of treatment, and decreasing stigma in many settings
Benefits/impact of VCT

- Study in ANC clinic in Côte d’Ivoire found that counseling was associated with discussion with partner about HIV risk reduction including condom use and male partner testing
  - Without counseling, negative test in female partner may give male the impression that he doesn’t need to test
Benefits/impact of VCT

- Other studies don’t find impact/ benefits with ‘routine’ VCT
  - Acceptance of VCT higher among those with fewer risk factors
  - No effect on subsequent risk factors or HIV incidence
Selection, training and supervision of counselors
Selection, training and supervision of counselors

- Program managers (like us) tend to spend time arguing about technical content of the counseling guidelines and algorithms
- BUT: Real challenge is selection, training, supervision and motivation
  - Many counseling interventions found to effective when implemented on small scale under controlled conditions
  - Effectiveness lost when implemented at scale as part of routine programs
Why selection, training, supervision and motivation matter

**Measles immunization**
- Vaccine stimulates antibody production, even if health worker is bored or apathetic when giving the injection

**Counseling**
- Counseling has limited effectiveness if health worker is bored or apathetic when giving the counseling
- Meta-message contradicts the message
Types of counselors: counseling only or multiple responsibilities

1. Provider with exclusive focus on counseling
   – Professional identity/title is counselor, training is primarily about counseling

2. Multi-purpose provider conducts counseling
   – Alongside other responsibilities in clinical care, social work, community mobilization etc.
Who can be counselors?

- Health workers providing general services
- Health workers specialized as counselors
- Community health workers and other community-based voluntary workers
- Peer educators
  - Recovering addicts
  - Members of same occupational group e.g. Commercial sex workers
  - People of same age & gender in general
Selecting counselors

- Can be helpful if similar to client
- Does not require advanced degree
- Need to avoid people accustomed to, or preferring, one-way provision of information
  - In interviewing candidates, helpful to provide a scenario and see how the person responds to it
  - “Suppose you are counseling a commercial sex worker who is HIV positive and continuing to work, and not insisting her clients use condoms...”
Selecting counselors

- Some programs select more counselors for training than they plan to hire, and only hire those who demonstrate proficiency in counseling by the end of the training
  - Strengths and weaknesses of this?

- Experienced health workers sometimes make poor counselors, in spite of their experience, as they have developed ineffective patterns of communication
Training of counselors

- Need well-defined counseling guidelines and job aids prior to training
- Training should provide time for:
  - Technical background on the health problem
  - Understanding the negotiation process
  - Role-playing of different scenarios
  - Qualitative interviewers excellent resource for role-playing, can play role of informants interviewed
Supervision of counselors

- Difficult to do well, need to find supervisors who themselves are good counselors
  - Some programs promote the best counselors to serve as supervisors
  - Also qualitative interviewers from formative research can be supervisors
- Role playing of counseling scenarios is effective, requires taking the counselor away from the work for a while
Supervision of counselors

- Supervision needs to be supportive
- Burnout a major issue, especially in VCT for HIV/AIDS
  - Major factor is volume of people to be counseled, counselors may be seeing 20-30 women per day, several of whom will be found to be positive
  - Counselors may also be performing other demanding duties e.g. midwifery, nursing
- Should provide regular opportunity for counselors to receive counseling
- Allow/plan for support groups for counselors
Counseling and the private domain
Counseling and the private domain

- Drawing on concepts from last class, one could think about counseling as:
  - Expression of recommendations originating in the public domain, and negotiation around how they might be put into practice in the private domain
- Personalized and confidential nature of counseling makes it more private, less public
Counseling and the private domain

- Additional steps taken to make counseling ‘more private’ or ‘domesticate’ counseling
  - Provision of counseling in the home
  - Counselor wears less formal clothing, rather than health worker uniform
  - Office where counseling occurs decorated to be more ‘domestic’
  - Inclusion of other household members in the counseling: spouse, senior household males and females
Implementing counseling interventions at the household and community levels
Implementing counseling interventions at the household and community levels

- For maximum impact, we want to implement counseling outside of health facilities, bring counseling closer to the people and into the home
  - Promote new behaviors right where they need to happen
  - Involve all household actors
  - Discuss topics that less powerful household members cannot broach
Implementing counseling interventions at the household and community levels

- Challenges
  - Supervision
  - Motivation
  - Balance with responsibilities for treatment
Does provision of treatments mix with counseling?

- If counselor (e.g. CHW or other community volunteer) has no drugs, may have low credibility: “this person only has words”
- If counselor has drugs, counseling may be seen as responsibility of only secondary importance
Motivation example: Project Accept
Project Accept

- Phase III randomized controlled research trial of a community-level behavioral intervention with HIV incidence as endpoint in South Africa, Tanzania, Thailand, and Zimbabwe
Project Accept

- Compare two approaches to Volunteer Counseling and Testing (VCT)
  - Clinic-based VCT or individually-orientated VCT (Standard VCT or SVCT)
  - Community based VCT (CBVCT)
    - engaging the community through outreach
    - taking VCT to people via mobile caravans
    - providing post-test support

- Motivation of volunteer counselors found to be major problem, focus of doctoral dissertation research of Anne Palaia at Tanzania site
Motivation in Project Accept Tanzania - 1

- Want additional training, beyond counseling, want role in treatment
  - “I beg {the project} to give us more power different from what we were having for mobilization and to educate community members... I should be given further education so as to become a services provider to the community and to remove the problem”
Motivation in Project Accept
Tanzania - 2

- Some want permanent working space, transport etc. like facility-based workers + more materials
  - “The materials are not enough for my work; I don’t have transport, no pen for writing, or exercise books for writing, no office or the main place where I can be found.”
  - “First they should sponsor us.... They should give us transport facilities like bicycles, some allowances maybe per month 100 shillings or 200 shillings for soap, you see. Also work tools like brochures, posters, they bring for us so that we can usher them out in the community.”
Motivation in Project Accept Tanzania - 3

- Some face scorn, derision from community
  - “It is also difficult, because you can come across someone who does not understand you at all and he ends up telling you to take your silly condoms.... Others hurl direct insults to you, “Wait I will put it on then try it on you.” For sure you find this work hard when it comes to situations like that, because I am an old respected woman.”
Formative research to develop counseling interventions
What is formative research?
Formative research to develop counseling interventions

Typically in three phases

1. Exploratory: Understand determinants of the problem, barriers to accessing care, client needs and preferences etc.

2. Prepare draft algorithm/decision tree, counseling protocol, visual aids, forms

3. Pre-testing of individual visual aids/print materials and of entire counseling protocol
<table>
<thead>
<tr>
<th>Greet</th>
<th>Greet clients warmly. Be polite, respectful and attentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask</td>
<td>Ask clients about themselves, reasons for coming, concerns, worries, etc.</td>
</tr>
<tr>
<td>Tell</td>
<td>Tell clients about their choices to prevent pregnancy and HIV / STIs</td>
</tr>
<tr>
<td>Help</td>
<td>Help clients choose the best way to prevent pregnancy and HIV / STIs</td>
</tr>
<tr>
<td>Encourage</td>
<td>Encourage clients to develop their Healthy Life Plan</td>
</tr>
<tr>
<td>Remind</td>
<td>Remind clients to come back</td>
</tr>
</tbody>
</table>
Formative research to develop counseling interventions

- First step should be to identify what already exists
  - Manuals/guidelines: Check websites of UNAIDS, WHO, UNICEF, FHI, CCP, Jhpiego, JSI, MSH, various NGOs etc.
  - MOH policies and guidelines
  - Visual aids
  - Reports and published articles
Formative research to develop counseling interventions

- Recruit and train qualitative interviewers
- Conduct formative research & pre-testing
- “Recycle” qualitative interviewers as trainers or supervisors
Formative research to develop counseling interventions

- Recruit and train qualitative interviewers
- Conduct formative research & pre-testing
- “Recycle” qualitative interviewers as trainers or supervisors

**Advantages of this approach:**
- Offer interviewers a longer contract
- Interviewers apply findings/lessons of formative phase in training and supervision
- Interviewers more effective in role-playing
Peer education interventions

Original slides developed by Amy Medley
What is peer education?

- **Various definitions:**
  - Training and supporting members of a given group to effect change among members of the same group.
  - Peers, matched demographically or by risk factor to the target population, deliver a health message through one-on-one interaction or small group discussion.

- **Key part of both definitions:**
  - Peers are members of the target group.
  - Assumption is that as members of target group peers will be more trusted and have more access through everyday interactions than non-members.
Peer education can be used to target different levels

- **Individual level:**
  - Peer education aims to modify a person’s knowledge and behaviors by using peers to deliver a health message

- **Group/societal level:**
  - Peer education used to modify social norms and stimulate collective action that leads to changes in programs and policies
Peer education can take different forms: Structured (formal) format

- Intervention delivered in highly structured settings such as a classroom or other venue
- Meetings are set up between peers and target group expressly for the purpose of delivering health message
- Often a large amount of supervision by non-peers
- This approach often used with youth programs
Peer education can take different forms: unstructured (informal) format

- Peers deliver their health message during the course of normal conversation and interactions in everyday life
- Supervision by non-peers often minimal
- Best for reaching hidden populations
Why is peer education a useful strategy: 3 E’s (Milburn, 1995)

- **Economy**
  - More cost-effective than other interventions because uses volunteers or minimally paid peers to deliver information instead of expensive health workers

- **Empowerment**
  - To both peer educators and target group
Why is peer education a useful strategy: 3 E’s (Milburn, 1995)

- **Efficacy**
  - Peers are seen as credible messengers by target group
  - They can pass on information easier than health professionals because people identify with peers
  - Utilizes already established means of sharing information and advice (i.e. existing social networks)
  - Peer education can be used to educate populations that are hard to reach through conventional methods
### Cost-effectiveness of interventions to prevent HIV in US among MSM (Pinkerton 2001)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Per-client program cost (US$)</th>
<th>Cost per infection averted (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer leader intervention</td>
<td>40</td>
<td>69,568</td>
</tr>
<tr>
<td>Counseling and testing</td>
<td>1844</td>
<td>184,400</td>
</tr>
<tr>
<td>Post-exposure prophylaxis</td>
<td>657</td>
<td>334,862</td>
</tr>
</tbody>
</table>
Does peer education empower peer educators?

- Case study from England (Strange, 2002)
  - 27 schools randomly assigned to receive peer-ed or to be control
  - Year 12 students (age 16-17) were trained as peer educators
  - Delivered a series of classroom-based peer led discussions to Year 9 students (age 13-14 years)

- After the intervention, peer educators reported an increase in their own:
  - Sexual knowledge
  - Ability to handle personal questions/talk about sensitive issues
  - Confidence to speak to large groups
Peer education not always positive for the peer educator

- Sometimes, peer role models may not maintain desired health behavior
- Case study—Injecting drug users in U.S.
  - Used former drug users as peer educators within drug using communities
  - Some peer educators resumed own drug use after involvement in program
- Paradox: IDUs are the best people for peer educators because understand situation and are highly motivated but fear they will relapse
Medley et al. 2009: Systemic review of 30 articles on peer education in HIV/AIDS programs

- Of the 30 studies:
  - 18 showed peer education was effective at increasing HIV knowledge
  - 4 showed less needle/syringe sharing among injection drug users
  - 19 studies measured condom use, overall significant effect but no effect for youth
  - 7 studies measured STI incidence, 3 showed a significant increase
Selection of peer educators

- Who is a peer?
  - How closely do they have to be matched to the target audience?
  - Is it enough that peers are the same age or have the same risk profile?

- How do you recruit peers?
  - Volunteers
  - Formative research
  - Nomination by target audience
  - Nomination by community groups/ village government

- See findings on recruitment, p 187, Medley et al.
Credibility of peer educators

- “This community at least they can listen to a medical person but if you use a mentor they say this one was given money, he is money based. What kind of a man is he? He is a spoilt man but if this was done by a health person or a health worker I think they can pay attention to him.” (Male, HIV-infected, aged 42, study of peer education in Uganda)
Training and supervision of peer educators

- Too much supervision can cause resentment

- Too little supervision can lead to:
  - Poor retention
  - Peer educators feeling abandoned/not well supported
  - Peer educators not delivering intended message.
Incentives for peer educators

- Should you provide material incentives to peer educators?
  - Money
  - Bicycles for transport
  - T-shirts/hats to make them feel part of group

- What effect could this have on their performance and credibility in the community?